STANFORD UNIVERSITY,
CENTER FOR HEALTH POLICY,
Stanford, CA, November 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT: On behalf of my colleagues, a group of distinguished economists, I am pleased to transmit this letter regarding essential components of health reform legislation.

Sincerely yours,

Alan M. Garber, M.D., Ph.D.

Henry J. Kaiser, Jr., Professor, Professor of Medicine, Professor of Economics, Health Research and Policy, and of Economics in the Graduate School of Business (courtesy), Director, Center for Primary Care and Outcomes Research and Center for Health Policy Stanford University.

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NOVEMBER 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT, As the full Senate prepares to debate comprehensive health reform legislation, we write as economists to stress the potential benefits of health reform for our nation's fiscal health, and the importance of those features of the bill that can help keep health care costs under control. Four elements of the legislation are critical: (1) deficit neutrality, (2) an excise tax on high-cost insurance plans, (3) an independent Medicare commission, and (4) delivery system reforms.

Including these four elements in the reform legislation—as the Senate Finance Committee bill does and as we hope the bill brought to the Senate floor will do—will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care, to a system that consistently delivers higher-quality, high-value care. The projected increases in federal budget deficits, along with concerns about the value of the health care that Americans receive, make it particularly important to enact fiscally responsible and quality-improving health reform now.

In developing our analysis and recommendation, we received input and suggestions from Administration officials, including the Office of Management and Budget and others, as well as from economists who disagree with the Administration's views.

The four key measures are:

Deficit neutrality. Fiscally responsible health reform requires budget neutrality or deficit reduction over the coming years. The Congressional Budget Office (CBO) must project that the bill be at least deficit neutral over the 10–year budget window, and deficit reducing thereafter. Covering tens of millions of currently uninsured people will increase spending, but the draft health reform legislation contains offsetting savings sufficient to cover those costs and the seeds of further reforms that will lower the growth of spending. Deficit neutrality over the first decade means that, even during the start-up period, the legislation will not add to our deficits. After the first decade, the legislation should reduce deficits.

Excise tax on high-cost insurance plans. The Senate Finance Committee's bill includes an excise tax on high-cost health insurance plans. Like any tax, the excise tax will raise federal revenues, but it has additional advantages for the health care system that are essential. The excise tax will help curtail the growth of private health insurance premiums by creating incentives to limit the costs of plans to a tax-free amount. In addition, as employers and health plans redesign their benefits to reduce health care premiums, cash wages will increase. Analysis of the Senate Finance Committee's proposal suggests that the excise tax on high-cost insurance plans would increase workers' take-home pay by more than $300 billion over the next decade. This provision offers the most promising approach to reducing private-sector health care costs while also giving a much needed raise to the tens of millions of Americans who receive insurance through their employers.

Medicare Commission. Rising Medicare expenditures pose one of the most difficult fiscal challenges facing the federal government. Medicare is technically complex and the benefits it underwrites are of critical importance to tens of millions of seniors and Americans with disabilities. We believe that a commission of medical experts should be empowered to suggest changes in Medicare to improve the quality and value of services. In particular, such a commission should be charged with developing and suggesting to Congress plans to extend the solvency of the Medicare program and improve the quality of care delivered to Medicare beneficiaries. Creating such a commission will make sure that reforming the health care system does not end with this legislation, but continues in future decades, with new efforts to improve quality and contain costs.

Delivery system reforms. Successful reform should improve the care that individual patients receive by rewarding health care professionals for providing better care, not just more care. Studies have shown that hundreds of billions of dollars are spent on care that does nothing to improve health outcomes. This is largely a consequence of the distorted incentives associated with paying for volume rather than quality. Health care reform must take steps to change the way providers care for patients, to reward care that is better coordinated and meets the needs of each patient. In particular, the legislation should include additional funding for research into what tests and treatments work and which ones do not. It must also provide incentives for physicians and hospitals to focus on quality, such as bundled payments and accountable care organizations, as well as penalties for unnecessary readmissions and health-facility acquired infections. Aggressive pilot projects should be rapidly introduced and evaluated, with the best strategies adopted quickly throughout the health care system.

As economists, we believe that it is important to enact health reform, and it is essential that health reform include these four features that will lower health care costs and help reduce deficits over the long term. Reform legislation that embodies these four elements can go a long way toward delivering better health care, and better value, to Americans.

Sincerely,

Dr. Henry Aaron, The Brookings Institution.

Dr. Kenneth Arrow, Stanford University, Nobel Laureate in Economics.

Dr. Alan Auerbach, University of California, Berkeley.

Dr. Katherine Baicker, Harvard University.

Dr. Alan Blinder, Princeton University.

Dr. David Cutler, Harvard University.

Dr. Angus Deaton, Princeton University.

Dr. J. Bradford DeLong, University of California, Berkeley.

Dr. Peter Diamond, Massachusetts Institute of Technology.

Dr. Victor Fuchs, Stanford University.

Dr. Alan Garber, Stanford University.

Dr. Jonathan Gruber, Massachusetts Institute of Technology.

Dr. Mark McClellan, The Brookings Institution.

Dr. Daniel McFadden, University of California, Berkeley, Nobel Laureate in Economics.

Dr. David Meltzer, University of Chicago.

Dr. Joseph Newhouse, Harvard University.

Dr. Uwe Reinhardt, Princeton University.

Dr. Robert Reischauer, The Urban Institute.

Dr. Alice Rivlin, The Brookings Institution.

Dr. Meredith Rosenthal, Harvard University.

Dr. John Shoven, Stanford University.

Dr. Jonathan Skinner, Dartmouth College.

Dr. Laura D'Andrea Tyson, University of California, Berkeley.

Mr. BAUCUS. The CMS Actuary agrees that this bill bends the cost curve. The folks at the Commonwealth Fund say the bill will save families $2,000 per year.

Mr. President, I ask unanimous consent that an excerpt from Dr. Gawande's article from the New Yorker be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

EXCERPT FROM GAWANDE ARTICLE IN NEW YORKER

There are hundreds of pages of these programs, almost all of which appear in the House bill as well. But the Senate reform package goes a few U.S.D.A.-like steps further. It creates a center to generate innovations in paying for and organizing care. It creates an independent Medicare advisory commission, which would sort through all the pilot results and make recommendations that would automatically take effect unless Congress blocks them. It also takes a decisive step in changing how insurance companies deal with the costs of health care. In the nineteen-eighties, H.M.O.s tried to control costs by directly overruling doctors' recommendations (through requiring pre-authorization and denying payment); the backlash taught them that it was far easier to avoid sicker patients and pass along cost increases to employers. Both the House and the Senate bills prevent insurance companies from excluding patients. But the Senate plan also imposes an excise tax on the most expensive, ''Cadillac'' insurance plans. This pushes private insurers to make the same efforts that public insurers will make to test incentives and programs that encourage clinicians to keep costs down.

Mr. BAUCUS. Mr. President, the Senator from Oklahoma at one point questioned the constitutionality of the mandate to buy health insurance. I might say, we thoroughly studied this issue. I believe there is ample authority for Congress to enact such a provision under the Commerce Clause, and also under the congressional authority to tax and spend for the general welfare provided for in the Constitution.

I might also add, Prof. Mark Hall of Wake Forest University has done an excellent survey article on this subject. Mr. President, I ask unanimous consent that the conclusion of Professor Hall's article, found at www.oneillinstitute.org, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows: